MOD Blue Cross PPO℠ P7 (Prudent Buyer 250/15/90/70)

PPO Benefits

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Members are also responsible for all costs over the plan maximums.

Plan maximums and other important information appear in *italics*.

Explanation of Covered Expense
Plan payments apply to the lesser of the charges billed by the provider or the following:
PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount. Non-PPO Providers & Other Health Care Providers *(includes those not represented in the PPO provider network)*—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the allowed amount & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for Non-Participating providers	$250/member; maximum of three separate deductibles/family
Deductible for non-Blue Cross PPO hospital or residential treatment center	$500/admission *(waived for emergency admission)*
Deductible for non-Blue Cross PPO hospital, residential treatment center or ambulatory surgical center if services not preauthorized	$500/admission *(waived for emergency admission)*
Deductible for emergency room services	$25/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums	
PPO Providers & Other Health Care Providers	$1,000/member/year
Non-PPO Providers	$3,000/member/year

The following do not apply to out-of-pocket maximums: deductibles listed above; dollar copays; percentage copays for mental or nervous disorders & substance abuse; non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for dollar copays; percentage copays for mental or nervous disorders & substance abuse; and, for non-PPO providers & other health care providers, costs in excess of the covered expense.

Lifetime Maximum	$5,000,000/member	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Hospital Medical Services *(preauthorization required: waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	30%[1]
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	30%[1]
Ambulatory Surgical Centers *(preauthorization required: waived for emergency admissions)*		
➢ Outpatient surgery, services & supplies	10%	30% *(limited to $350/day)*
Skilled Nursing Facility *(preauthorization required)*		
➢ Semi-private room, services & supplies *(medical conditions & severe mental disorders limited to 100 days/calendar year; treatment of substance abuse limited to 30 days/calendar year)*	10%	30%
Hospice Care		
➢ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services	20%[2]	

[1]For California facilities, a discount applies if the facility has a contract with Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.

[2]These providers are not represented in the Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Home Health Care *(preauthorization required)*		
➢ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	10%	30%
Home Infusion Therapy *(preauthorization required)*	10%	30%
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services		*(limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	$15/visit[1] *(deductible waived)*	30%
➢ Hospital & skilled nursing facility visits	10%	30%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
Diagnostic X-ray & Lab *(including mammograms, Pap smears, & prostate cancer screenings)*	10%	30%
Well Baby & Well-Child Care for Dependent Children		
➢ Routine physical examinations *(birth through age six)*	$25/exam *(deductible waived)*	30% *(limited to $20/exam)*
➢ Immunizations *(birth through age six)* & immunizations for Hepatitis B & Varicella Zoster (Chicken Pox) *(ages 7 through 18)*	No copay *(deductible waived)*	30% *(limited to $12/immunization)*
Preventive Care for Members Ages Seven & Older		
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam *(limited to $1000/calendar year)*	$25/visit *(deductible waived)*	Not covered
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 24 visits/calendar year; additional visits may be authorized)*	10%	30% *(limited to $25/visit)*
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	10%	30%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to $25/visit & 12 visits/calendar year)*	10%[2]	30%[2]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	30%
Pregnancy & Maternity Care *(services cover subscriber, spouse & dependent daughters)*		
➢ Physician office visits	$15/visit[1] *(deductible waived)*	30%
➢ Prescription drug for elective abortion *(mifepristone)*	10%	30%
Normal delivery, cesarean section, comp lications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse)*		
➢ Inpatient physician services	10%	30%
➢ Hospital & ancillary services	10%	30%[3]
Organ & Tissue Transplants *(preauthorization required; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	
➢ Physician office visits *(including specialists and consultants)*	$15/visit[1] *(deductible waived)*	

[1]The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery).

[2]Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

[3]For California facilities, a discount applies if the facility has a contract with Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Organ & Tissue Transplants (continued)		
➢ Transplant travel expense for an authorized, specified transplant at a COE *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*	No copay *(deductible waived)*	
MedCall®		
➢ A 24-hour service that connects members to a nurse or audio library with a toll-free call; the number is printed on the member's ID card	No copay *(deductible waived)*	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$15/visit *(deductible waived)*	30%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; & the first pair of contact lenses or eyeglasses when required as a result of eye surgery *(limited to $2,000/calendar year except for prostheses following a mastectomy or prosthetic devices following a laryngectomy)*	10%	30%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies, & therapeutic shoes & inserts for members with diabetes *(limited to $10,000/calendar year)*	10%	30%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[1]	
Emergency Care		
➢ Emergency room services & supplies *($25 deductible waived if admitted)*	10%	10%
➢ Inpatient hospital services & supplies	10%	10% first 48 hours; 30%[2] after 48 hours *(unless member can't be moved safely)*
➢ Ambulatory surgical center services & supplies	10%	10%
➢ Physician services	10%	10%
Mental or Nervous Disorders		
➢ Facility-based care *(preauthorization required; waived for emergency admissions; limited to $175/day)*	10%[3]	30%[2, 3]
➢ Inpatient or outpatient physician visits for psychotherapy & psychological testing *(limited to $25/visit)*	10%[3]	30%[3]
Substance Abuse		
➢ Facility-based care *(preauthorization required; waived for emergency admissions; limited to $175/day & 30 days/calendar year; the 30 days/calendar year limit does not apply to inpatient detoxification)*	10%	30%[2]
➢ Inpatient or outpatient physician visits *(limited to $25/visit & 50 visits/calendar year)*	10%	30%

[1]These providers are not represented in the Blue Cross PPO network.

[2]For California facilities, a discount applies if the facility has a contract with Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.

[3]These exclusions, copays and benefit maximums do not apply to severe mental disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, bulimia, and serious emotional disturbances of children as defined in California state law (other than primary substance abuse or developmental disorder). Severe mental disorders are subject to the same copays and benefit maximums applicable to other medical conditions for covered services. In order to receive maximum benefits, services must be rendered by a Blue Cross behavioral health provider. Please see the EOC for complete information.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Blue Cross PPO—Prudent Buyer Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. However, if member has a life-threatening or seriously debilitating condition and we determine that the requested treatment is not a covered service because it is experimental or investigative, the member may request an independent medical review as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the Evidence of Coverage (EOC).

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the insured person for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the EOC.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited, to dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, unless it is for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by our Medical Policy.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications as specified as covered in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the EOC.

Exercise Equipment. Exercise equipment or any charges for activities, instrumentalities or facilities normally intended or used for developing or maintaining physical fitness including, but not limited to, charges from a physical fitness instructor, or health club or gym, even if ordered by a physician.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specifically provided or arranged by us, or as specified as covered in the EOC.

Food Supplements. Food or dietary supplements, except as specified as covered in the EOC.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

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Pre-Existing Condition Exclusion – No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse, or to conditions of pregnancy. Also if a member was covered under creditable coverage, as outlined in the member's EOC, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

Third Party Liability – Blue Cross of California is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits – The benefits of this plan may be reduced if the member has any other group health, dental, prescription drug or vision coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

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